114.1 CMR 36.00: ACUTE CARE HOSPITAL CHARGES AND RATES OF PAYMENT FOR CERTAIN PUBLICLY ASSISTED INDIVIDUALS

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36.01: General Provisions

(1) Scope, Purpose, and Effective Date.

(a) 114.1 CMR 36.00 implements the provisions of M.G.L. 118G regarding acute hospitals.

(b) 114.1 CMR 36.00 sets forth the methods used to determine reasonable financial requirements of Disproportionate Share Hospitals and governs the Title XIX rates of payment effective October 1, 2004 for Disproportionate Share Hospitals, emergency services not covered by an agreement with EOHHS , and Sole Community Providers.

(2) Authority. 114.1 CMR 36.00 is adopted pursuant to M.G.L. 118G.

(3) Disclaimer of Authorization of Services. 114.1 CMR 36.00 is neither authorization for nor approval of the substantive services for which rates are determined pursuant to 114.1 CMR 36.00. Governmental units that purchase services from eligible providers are responsible for the definition, authorization, and approval of services extended to publicly assisted clients.

(4) Overview. The Medicaid rates established in 114.1 CMR 36.05 and 114.1 CMR 36.06 do not apply to the following:
   (a) mental health and substance abuse services reimbursable by EOHHS's Behavioral Health (BH) contractor;
   (b) services provided to Medicaid patients enrolled in managed care organizations;
   (c) air ambulance services;
   (d) hospital services reimbursed through other contracts or regulations; or,
   (e) non-acute services in acute hospitals, except as noted in 114.1 CMR 36.05(8).

36.02: Definitions

Actual Average APG Weight Per Episode. An index of resources used, on average, in the PAPE base year to treat a MassHealth Member in the hospital outpatient department or HLHC, as measured using the weights from MassHealth's APG Payment System based on actual MassHealth payments for services provided. . In calculating the Actual Average APG Weight, MassHealth repriced claims for April 1, 2003 through September 30, 2003, as though the payment for outlier episodes had not been eliminated.
Acute Hospital. A hospital licensed under M.G.L. c. 111, § 51 that contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the Department of Public Health.

Administrative Day (AD). A day of inpatient hospitalization on which a member's care needs can be provided in a setting other than an acute hospital, and on which the member is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available. See 130 CMR 415.415 and 415.416.

Administrative Day Per Diem. An all-inclusive per diem payable to hospitals for administrative days.

Ambulatory Patient Group (APG). A group of outpatient services that have been bundled for purposes of categorizing and measuring casemix. It is based on the 3M Corporation's APG version 2.0 Grouper.

Ambulatory Payment Group Payment System (APG Payment System). The payment system described in MassHealth's Acute Hospital RFA and Contract effective February 1, 2002.

Behavioral Health (BH) Contractor. The entity with which EOHHS contracts to administer the MassHealth Behavioral Health Program.

Behavioral Health Program (BHP). A managed care program for the provision of mental health and substance abuse services to MassHealth members enrolled in the program.

Casemix. The description and categorization of a hospital's patient population according to criteria approved by the Division including, but not limited to, primary and secondary diagnoses, primary and secondary procedures, illness severity, patient age and source of payment.

Centers for Medicare and Medicaid Services (CMS). The federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

Charge. The uniform price for each specific service within a revenue center of an acute hospital.

Clinical Laboratory Service. Microbiological, serological, chemical, hematological, biophysical, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

Commissioner. The Commissioner of the Division of Health Care Finance and Policy (DHCFP).

Community-Based Entity. Any entity that is not a hospital-based entity.

Community-Based Physician. Any physician, excluding interns, residents, fellows, and house officers, who is not a hospital-based physician. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths.

Comparison APG Payment. A calculation of the amount EOHHS would have paid for outpatient services, except those described in 1141. CMR 36.06 (2) (f), provided to MassHealth Members in RY04 using the APG payment system.

Comprehensive Cancer Center. The hospital of any institution so designated by the national cancer institute under the authority of 42 USC §§ 408(a) and 408(b) organized solely for the treatment of cancer, and offered exemption from the Medicare diagnosis related group payment system under 42 CFR 405.475(f).

Disproportionate Share Hospital. Any acute hospital that exhibits a payer mix where a minimum of 63% of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the federal Social Security Act, other government payers and free care.

Division. The Division of Health Care Finance and Policy (DHCFP).

Early Maternity Discharge. A discharge from inpatient care less than 48 hours after a vaginal delivery and less than 96 hours after a caesarean delivery.

Emergency Department (E.D.). A hospital's Emergency Room or Level I Trauma Center that is located at the same site as the hospital's inpatient department.

Emergency Medical Condition. A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of a Member or another person or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Emergency Services. Covered inpatient and outpatient services, including behavioral health services, that are furnished to a Member by a provider that is qualified to furnish such services under Title XIX of the Social Security Act, and are needed to evaluate or stabilize a Member's emergency medical condition.

Episode. All outpatient services, except those described in 114.1 CMR 36.06 (2) (f), delivered to a MassHealth Member where the services were delivered on a single calendar day.

Episode Cost. A hospital's cost for delivering an episode of care as determined by MassHealth. Episode Cost is the product of the hospital's charges for those claim lines of an episode that adjudicate to pay and the outpatient cost-to-charge ratio as calculated by DHCFP.

Excluded Units. Non-acute units as defined in 114.1 CMR 36.02; psychiatric and substance abuse units; and non-distinct observation units.

Executive Office of Health and Human Services (EOHHS). The single state agency that is responsible for the administration of the MassHealth Program, pursuant to M.G.L c. 118E and Titles XIX and XXI of the Social Security Act and other applicable laws and waivers.

Fiscal Year. The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year.

Governmental Unit. The Commonwealth or any department, agency board, commission, or political subdivision of the Commonwealth.

Gross Patient Service Revenue. The total dollar amount of a hospital's charges for services rendered in a fiscal year.

Hospital. See Acute Hospital.

Hospital-Based Entity. Any entity that contracts with a hospital to provide hospital services to Members.

Hospital-Based Physician. Any physician, excluding interns, residents, fellows, and house officers, who contracts with a hospital or hospital-based entity to provide hospital services to Members. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives, and physician assistants are not hospital-based physicians.

Hospital-Licensed Health Center (HLHC). A facility that is not physically attached to the hospital that: (1) operates under the hospital's license; (2) meets MasHealth requirements for reimbursement as an HLHC as provided at 130 CMR 410.413; (3) is approved by and enrolled with the MassHealth Provider Enrollment Unit as an HLHC; (4) possesses a distinct HLHC provider number issued by MassHealth; (5) is subject to the fiscal, administrative, and clinical management of the hospital; and, (6) provides services to Members solely on an outpatient basis.

Inpatient Admission. The admission of a Member to an acute hospital for the purposes of receiving inpatient services in that hospital.

Managed Care Organization (MCO). Any entity with which EOHHS contracts to provide primary care and certain other medical services on a capitated basis, including an entity that is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO) or that otherwise meets the state plan definition of an HMO.

MassHealth (also Medicaid). The Medical Assistance Program administered by EOHHS to furnish and pay for medical services pursuant to M.G.L. c. 118E and Title XIX and XXI of the Social Security Act, and any approved waivers of such provisions.

Member. A person determined by the EOHHS to be eligible for medical assistance under the MassHealth program.

Non-Acute Unit. A chronic care, rehabilitation, or skilled nursing facility within a hospital.

Outlier Day. Each day beyond 20 acute days, during a single admission, for which a Member remains hospitalized at acute status, other than in a DMH-licensed bed.

Outpatient Department (also Hospital Outpatient Department). A department or unit located at the same site as the hospital's inpatient facility, or a School-Based Health Center that operates under the hospital's license and provides services to Members on an ambulatory basis. Hospital Outpatient Departments include day surgery units, primary care clinics, specialty clinics, and EDs.

Outpatient Services (also Outpatient Hospital Services). Medical services provided to a Member in a hospital outpatient department, hospital-licensed health center orsatellite clinic for which a reimbursement method is specified in 114.1 CMR 36.00. Such services include, but are not limited to, emergency services, primary care services, observation services, ancillary services, day surgery services, and recovery room services provided in the hospital.

Payment Amount Per Episode (PAPE). The hospital-specific payment for all PAPE-covered services provided by a hospital to a MassHealth Member on an outpatient basis in one episode.

PAPE-Covered Services. MassHealth-covered services provided by hospital outpatient departments or HLHCs, except those services described in 1141 CMR 36.06 (2) (f).

PPS-Exempt Hospitals. Those hospitals excluded from the Medicare outpatient prospective payment system as of July 1, 2003.

Projected Average APG Weight Per Episode. The hospital-specific average of the projected APG weights per episode for RY 05. The projected monthly average APG payments are the result of projecting the trend of statistically smoothed monthly average APG weights from January 2001-September 2003 through September 2005.

Pass-Through Costs. Organ acquisition, malpractice, and direct medical education costs that are paid on a cost-reimbursement basis and are added to the hospital-specific standard payment amount per discharge.

Patient. A person receiving health care services from a hospital.

Pediatric Specialty Hospital. A hospital licensed in Massachusetts under M.G.L. c. 111, §51, that limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

Pediatric Specialty Unit. A pediatric unit in an acute hospital in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeded 0.20, unless located in a facility already designated as a specialty hospital.

Primary Care. All health care and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or nurse practitioner, to the extent the furnishing of those services is legally authorized in the Commonwealth.

Private Sector Charges. Gross patient service revenues attributable to all patients less gross patient service revenue attributable to Titles XVIII and XIX, other publicly-aided patients, free care, and bad debt.

Provider. An individual or entity that has a written contract with EOHHS to provide medical goods or services to Members.

Public Service Hospital. Any public acute hospital or any acute hospital operating pursuant to St. 1995, c. 147, that has a private sector payer mix that constitutes less than 35% of its Gross Patient Service Revenue (GPSR) and where uncompensated care comprises more than 20% of its GPSR.

Purchaser. A person responsible for payment for health care services rendered by a hospital.

Rate Year (RY). Generally, the period beginning October 1 and ending September 30. RY05 will begin on October 1, 2004 and end on September 30, 2005.

Member

Repriced Average APG Weight Per Episode. An index of resources used, on average, in the PAPE base year to treat a MassHealth Member by the hospital outpatient department or HLHC, as measured by the APG payment system weights based on repriced total APG payment.

Repriced Total APG Payment. An adjusted calculation of total payment for PAPE-covered services provided to MassHealth Members in the PAPE base year using APG payment system, calculating the episode cost using the RY01 outpatient cost-to-charge ratio, and defining an episode as any PAPE-covered service provided to a MassHealth Member in the hospital outpatient department or HLHC in a calendar day. In calculating the Repriced Total APG Payment, MassHealth repriced claims for April 1, 2003 through September 30, 2003, as though the payment for outlier episodes had not been eliminated.

Revenue Center. A functioning unit of a hospital that provides distinctive services to a patient for a charge.

Satellite Clinic. A facility, other than an HLHC, that: (1) operates under a hospital's license; (2) is subject to the fiscal, administrative, and clinical management of that hospital; (3) provides services to Members solely on an outpatient basis; and, (4) is not located at the same site as the

hospital's inpatient facility; and, (5) demonstrates to EOHHS's satisfaction that it has CMS provider-based status in accordance with 42 CFR 413.65.

School-Based Health Center (SBHC). A center located in a school setting that: (1) provides health services to MassHealth Members under the age of 21; (2) operates under a hospital's license; (3) is subject to the fiscal, administrative, and clinical management of a hospital outpatient department or HLHC; and, (4) provides services to Members solely on an outpatient basis.

Sole Community Hospital. Any acute hospital: (1) classified as a sole community hospital by CMS Medicare regulations; or, (2) that demonstrates to the Division's satisfaction that it is located more than 25 miles from other acute hospitals in the Commonwealth and that it provides services for at least 60 percent of its primary service area; or, (3) as otherwise defined in M.G.L. c. 118G.

Specialty Hospital. Any acute hospital that limits admissions to children or to patients under active diagnosis and treatment of eyes, ears, nose, and throat, or diagnosis and treatment of cancer.

State Institution. Any hospital, sanatorium, infirmary, clinic or other such facility that is owned, operated, or administered by the Commonwealth, that furnishes general health supplies, care or rehabilitative services and accommodations.

Title XIX. Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., or any successor statute enacted into federal law for the same purposes as Title XIX.

Transfer Patient. Any inpatient who: (1) is transferred between acute hospitals; (2) is transferred between a DMH-licensed bed and a medical/surgical unit in an acute hospital; (3) is receiving substance abuse treatment or mental health-related services and whose assignment in the BHP changes; (4) becomes eligible for MassHealth after the date of admission and prior to the date of discharge; (5) is a Member who exhausts other insurance benefits after the date of admission and prior to the date of discharge; (6) transfers from the PCC Plan or non-managed care to an MCO, or from an MCO to the PCC Plan or non-managed care, after the date of admission; or, (7) has a primary diagnosis of mental illness in a non-DMH-licensed bed.

Usual and Customary Charges. Routine fees that hospitals charge for acute inpatient and outpatient services, regardless of payer source.

36:03: Freedom to Contract and to Modify Charges

(1) Charge Modifications. Charge modifications implemented by acute care hospitals are not subject to prior approval by the Division. Any acute hospital that makes a charge or

accepts a payment based upon a charge in excess of that filed with the Division shall be subject to penalties pursuant to 114.1 CMR 36.16.

(2) Freedom to Contract. Acute care hospitals may enter into contractual arrangements with purchasers and third party payers. No such arrangement, including but not limited to prices or charges which may be charged for non-contracted services or which may be negotiated in individual contracts between such acute care hospitals and such purchasers or third party payers, shall be subject to prior approval by the Division; provided, however, that charges established by an acute hospital for health care services rendered shall be uniform for all patients receiving comparable services.

36.04: Determination of Disproportionate Share Status under M.G.L. 118G

(1) Criteria for Determination of Disproportionate Share Status. The Division will determine the percentage of each hospital's gross patient service revenue (GPSR) attributable to Medicare, Medicaid, other governmental payers, and free care, using the data sources described in 114.1 CMR 36.04(2). If this percentage is greater than or equal to 63%, the hospital qualifies as a disproportionate share hospital.

(2) Data Sources for Determination of Disproportionate Share Status.

(a) For FY96 and thereafter, the Division will use the most recent submission of the hospital's DHCFP-403 Cost Report to obtain charges attributable to Medicare, Medicaid, other government payers, and total charges.

(b) The Division will obtain free care charge data from the hospital's UC-Form filings, on a fiscal year basis consistent with the data cited in 114.1 CMR 36.04(2)(a).

(c) For the purposes of determining disproportionate share status, the Division will include Medicare managed care GPSR as Medicare GPSR, and Medicaid managed care GPSR as Medicaid GPSR.

36.05: Determination of Medicaid Inpatient Payment Rates for Disproportionate Share Hospitals and Sole Community Hospitals

(1) Overview.

(a) Applicability. Except as otherwise provided in 114.1 CMR 36.01(4), 114.1 CMR 36.05 establishes Medicaid inpatient rates of payment to acute care hospitals that qualify for disproportionate share status and sole community hospitals under M.G.L. 118G and that enter into an agreement with EOHHS for provision of acute hospital services to MassHealth members. The Division determines eligibility for disproportionate share status pursuant to 114.1 CMR 36.04.

(b) Effective date. Unless as otherwise noted, 114.1 CMR 36.05 governs Medicaid rates for services provided from October 1, 2004 through September 30, 2005.

Rates for patients whose acute inpatient stay spans two different fiscal years shall be those rates in effect on the date of the patient's admission.

(2) Rates of Payment for Inpatient Services

(a) Overview. Except as otherwise provided in 114.1 CMR 36.01(4), 114.1 CMR 36.05 establishes the methodology for determining Medicaid rates of payment for covered inpatient services. The Medicaid rate of payment for covered inpatient services consists of a single hospital-specific payment amount per discharge. This hospital-specific payment amount equals the sum of:

1. a standard payment amount per discharge;
2. a pass-through payment amount per discharge for malpractice, organ acquisition, and direct medical education costs; and,
3. a capital payment amount per discharge.

(b) Standard Payment Amount per Discharge (SPAD). The standard payment amount per discharge for each hospital is derived by multiplying the RY05 statewide average payment amount per discharge of $2,991.90 by each hospital's MassHealth casemix index and Massachusetts specific wage area index. To develop the Hospital's RY05 casemix index, EOHHS used casemix discharge data submitted to DHCFP by the Hospital, as accepted into DHCFP's database as of July 9, 2004, for the period October 1, 2002, through September 30, 2003, which was then matched with the MassHealth SPAD and transfer claims for the same period to ensure that only MassHealth claims were included in the final casemix index calculations.

(c) Calculation of the Pass-Through Amount Per Discharge. The pass-through amount per discharge is the product of the per diem costs of inpatient malpractice, organ acquisition, and medical education costs and the hospital-specific Medicaid average length of stay from casemix data, excluding such costs related to services in excluded units.

The per diem malpractice cost is net of malpractice costs associated with services in excluded units. The days used in the denominator are also net of days associated with such units. The pass-through amount per discharge is derived from the FY03 DHCFP-403 cost report, as screened and updated as of July 9, 2004. Direct medical education costs will be subject to a primary care training incentive adjustment. The inpatient portion of direct medical education costs is derived from the FY03 DHCFP-403 Report as screened and updated as of July 9, 2004. The amount is calculated by dividing the hospital's inpatient portion of expenses, excluding such expenses related to services in excluded units, by the number of total inpatient days, also net of days associated with excluded units. This *per diem* amount is then multiplied by the hospital-specific Medicaid (non-psychiatric/substance abuse) average length of stay from casemix data. An incentive of 33% is added to the per discharge cost of primary care training, and a discount of 20% is subtracted from the per discharge cost of specialty care training, provided,

however, that the 20% reduction is not applied to the costs of specialty care resident training at Pediatric Specialty hospitals and hospitals with Pediatric Specialty Units. For the purposes of this provision, Primary Care resident training is training in internal medicine for general practice, family practice, OB/GYN, and pediatrics. Direct medical education costs are subject to audit by the EOHHS and/or DHCFP.

(d) Capital Payment Amount Per Discharge. The RY04 statewide weighted average capital cost per discharge is $365.44. The hospital-specific capital payment per discharge was determined by multiplying the statewide weighted average capital cost per discharge by the hospital's RY05 MassHealth casemix index.

(e) Admissions involving one-day length of stay following outpatient surgical services. If a patient who requires hospital inpatient services is admitted for a one-day stay following outpatient surgery, the hospital shall be paid at the transfer per diem rate established according to 114.1 CMR 36.05(4) instead of at the hospital's standard payment amount per discharge.

(f) Payments for newly-eligible members or in the event of exhaustion of other insurance. When a patient becomes newly Medicaid-eligible or if they become eligible because other insurance benefits have been exhausted after the date of admission and prior to the date of discharge, the acute stay is paid using the transfer *per diem* payment, established according to 114.1 CMR 36.05(4), up to the hospital-specific per discharge amount. If the patient is at administrative day status (AD), payment will be made at the AD *per diem,* as established in 114.1 CMR 36.05(5).

(g) Rate of payment for physician services. For physician services provided by hospital-based physicians to MassHealth patients, the hospital is reimbursed in accordance with, and subject to, the Physician Regulations at 130 CMR 433.000 *et seq*. Such reimbursement is at the lower of the fee in the most current promulgation of DHCFP fees as established in 114.3 CMR 16.00, 17.00, 18.00 and 20.00, or the hospital's usual and customary charge or 100% of the hospital's actual charge submitted.

Hospitals are reimbursed for such physician services only if the hospital-based physician or a physician providing services on behalf of a hospital-based entity took an active patient care role, as opposed to a supervisory role, in providing the inpatient service(s) on the billed date(s) of service. Physician services provided by residents and interns are reimbursed through the DME portion of the SPAD, and, as such, are not reimbursable separately.

Hospitals are not reimbursed for inpatient physician services provided by community-based physicians or entities.

(h) Maternity/Newborn rates. Delivery-related maternity cases are paid on the standard payment amount per discharge (SPAD) basis with one SPAD paid for the mother and one SPAD paid for the newborn. The rate includes payment for all services, except physician services, provided in conjunction with a maternity stay.

(3) Outlier rates of payment.

(a) Outlier Per Diem. A hospital qualifies for an outlier per diem payment equal to 60% of the hospital's transfer per diem in addition to the hospital-specific standard payment amount per discharge or transfer per diem payment if all of the following conditions are met: (1) the Medicaid non-managed care length of stay for the hospitalization exceeds 20 cumulative acute days (not including days in a DMH-licensed bed or days paid by a third party); (2) the hospital continues to fulfill its discharge planning duties as required in EOHHS regulations; (3) the patient continues to need acute level care and is therefore not on Administrative Day status on any day for which an outlier payment is claimed; (4) the patient is not a patient in a DMH-licensed bed on any day for which an outlier payment is claimed; (5) the patient is not a patient in a Non-Acute Unit within an Acute Hospital; and, (6) the patient is under 21 years of age.

(b) Pediatric Outlier Payment. In accordance with 42 U.S.C. 1396a(s), an annual pediatric outlier adjustment is made to acute care hospitals providing medically-necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay for children greater than one year of age and less than six years of age. Only hospitals that meet the Basic Federally-Mandated Disproportionate Share eligibility per 114.1 CMR 36.07(3) are eligible for the pediatric outlier payment. The Pediatric Outlier Payment is calculated using the data and methodology as follows:

1. Data Source. The prior year's claims data residing on EOHHS's Massachusetts Medicaid Information System is used to determine exceptionally high costs and exceptionally long lengths of stay.

2. Eligibility is determined by the Division as follows:

a. Exceptionally long lengths of stay: First, a statewide weighted average Medicaid inpatient length of stay is calculated. This is determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of Medicaid discharges for all acute care hospitals in the state. Second, the statewide weighted standard deviation for Medicaid inpatient length of stay is calculated. Third, the statewide weighted standard deviation for Medicaid inpatient length of stay is multiplied by two and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold Medicaid exceptionally long length of stay.

b. Exceptionally high cost. Exceptionally high cost is calculated for hospitals providing services to children greater than one year of age and less than six years of age by the Division as follows:

1. First, the average cost per Medicaid inpatient discharge for each hospital is calculated.

2. Second, the standard deviation for the cost per Medicaid inpatient discharge for each hospital is calculated.

3. Third, the hospital's standard deviation for the cost per Medicaid inpatient discharge is multiplied by two and added to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each hospital's threshold Medicaid exceptionally high cost.

c. Eligibility for a Pediatric Outlier Payment. For hospitals providing services to children greater than one year of age and under six years of age, the Division calculates the following:

1. the average Medicaid inpatient length of stay involving children greater than one year of age and less than six years of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in 114.1 CMR 36.05(3)(c)2.a., then the hospital is eligible for a Pediatric Outlier Payment.

2. the cost per inpatient Medicaid case involving children greater than one year of age and less than six years of age. If this hospital-specific Medicaid inpatient cost equals or exceeds the threshold defined in 114.1 CMR 36.05(3)(c)2.b., then the hospital is eligible for a Pediatric Outlier Payment.

3. Payment to Hospitals. Hospitals qualifying for an outlier adjustment in the payment amount pursuant to 114.1 CMR 36.05, receive 1/2% of the total funds allocated for payment to acute hospitals under 114.1 CMR 36.07(3)(e). The total funds allocated for payment to acute hospitals under 114.1 CMR 36.07(3)(e) are reduced by the payment amount under 114.1 CMR 36.05(3)(c).

(c) Infant Outlier Payment. In accordance with 42 U.S.C. 1396a(s), an annual infant outlier payment adjustment is made to hospitals providing medically-necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay for infants under one year of age. The Infant Outlier Payment is calculated using the data and methodology as follows:

1. Data Source. The prior year's claims data residing on EOHHS's Massachusetts Medicaid Information System is used to determine exceptionally high costs and exceptionally long lengths of stay.

2. Eligibility is determined by the Division as follows:

a. Exceptionally Long Lengths of Stay: The statewide weighted average Medicaid inpatient length of stay is determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of Medicaid discharges for all acute care hospitals in the state. The statewide weighted standard deviation for Medicaid

inpatient length of stay is also calculated. The statewide weighted standard deviation for the Medicaid inpatient length of stay is multiplied by two, and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold figure for Medicaid exceptionally long length of stay.

b. Exceptionally High Cost is calculated for hospitals providing services to infants under one year of age by the Division as follows:

1. First, the average cost per Medicaid inpatient case for each hospital is calculated;

2. Second, the standard deviation for the cost per Medicaid inpatient case for each hospital is calculated;

3. Third, the hospital's standard deviation for the cost per Medicaid inpatient discharge is multiplied by two, and that amount is added to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each hospital's threshold Medicaid exceptionally high cost.

c. For each hospital providing services to infants under one year of age, the Division determines first, the average Medicaid inpatient length of stay involving individuals under one year of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in 114.1 CMR 36.05(3)(d)2.a., then the hospital is eligible for an infant outlier payment.

Second, the cost per inpatient Medicaid case involving infants under one year of age is calculated. If a hospital has a Medicaid inpatient case with a cost that equals or exceeds the hospital's own threshold defined in 114.1 CMR 36.05(3)(d)2.b. above, then the hospital is eligible for an infant outlier payment.

d. Payment to Hospitals. Annually, each hospital that qualifies for an outlier adjustment receives an equal portion of $50,000. For example, if two hospitals qualify for an outlier adjustment, each receives $25,000.

(4) Rates of payment for transfer patients. The text contained in 114.1 CMR 36.05(4) sets forth the payment rates applicable to transferred patients. Purchasing governmental units are responsible for the definition, authorization and approval of transfer services.

(a) Transfers between hospitals.

1. In general, the hospital that is receiving the patient will be paid on a per-discharge basis, in accordance with the methodology specified in 114.1 CMR 36.05(2), if the patient is actually discharged from that hospital. If the patient is transferred to another hospital, then the transferring hospital is paid at the hospital-specific transfer *per diem* rate up to the hospital-

specific SPAD. Additionally, "back transferring" hospitals are eligible for outlier payments specified in 114.1 CMR 36.05(3).

2. Except as otherwise provided in the following paragraph, the RY05 payment per day for transfer patients shall equal the statewide average payment amount per discharge divided by the FY98 average all-payer length of stay of 4.5035 days, to which is added the hospital-specific capital, direct medical education and pass-through per diem payments which are derived by dividing the per-discharge amount for each of these components by the hospital specific MassHealth average length of stay. For hospitals with unique circumstances as provided in 114.1 CMR 36.05(7), the RY04 payment amount per day for Transfer Patients shall equal the individual Hospital's standard inpatient payment amount per discharge divided by the FY98 average all-payer length of stay of 4.5035 days, to which is added the hospital-specific capital, direct medical education and pass-through per diem payments which are derived by dividing the per-discharge amount for each of these components by the hospital specific MassHealth average length of stay.

(b) Transfers within a hospital. In general, a transfer within a hospital is not considered a discharge. Consequently, in most cases a transfer between units within a hospital will be reimbursed on a transfer per diem basis capped at the hospital-specific SPAD. This section outlines reimbursement under some specific transfer circumstances.

1. Transfer to/from a non-acute unit within the same hospital. If a patient is transferred from an acute bed to a non-acute unit in the same hospital, the transfer is considered a discharge. EOHHS will pay the hospital-specific SPAD for the portion of the stay before the patient is transferred to a non-acute unit.
2. MassHealth payments for: newly-eligible Members; Members who change from the PCC plan or fee for service to an MCO, or from an MCO to the PCC plan or fee for service during a hospital stay; or, in the event of exhaustion of other insurance. When a patient becomes MassHealth-eligible, enrolls in or disenrolls from an MCO during the course of a hospital stay, or exhausts other insurance benefits after the date of admission and prior to the date of discharge, the acute stay will be paid at the transfer per diem rate, up to the hospital-specific SPAD, or, if the patient is at the Administrative Day (AD) level of care, at the AD per diem rate. When a patient enrolls in or disenrolls from an MCO during the hospital stay, the non-MCO days will be paid at the transfer per diem rate.
3. Transfer between a DMH-licensed bed and any other bed within the same hospital. Reimbursement for a transfer between a DMH-licensed

bed and any other bed within a hospital will vary depending on the circumstances involved, such as managed care status, BH network or non-network hospital, or the type of service provided. Refer to subsections (4)(a) and (b) below.

4. Change of BH managed care status during a psychiatric or substance abuse hospitalization.
   (a) Payments to hospitals without network provider agreements with EOHHS's BH Contractor. When a Member enrolls in the BHP during a non-emergency or emergency psychiatric or substance abuse admission at a non-network hospital, the portion of the hospital stay during which the Member is enrolled in the BHP shall be paid by EOHHS's BH Contractor provided that the hospital complies with the BH Contractor's service authorization and billing policies and procedures. If the BH Contractor offers to pay the Hospital at the RFA transfer per diem rate, capped at the Hospital-specific SPAD, for substance abuse services, and at the psychiatric per diem rate, capped at the hospital-specific SPAD for psychiatric services under these circumstances, the hospital must accept the BH Contractor rate offer for all such Members. This requirement does not prohibit the BH Contractor from choosing to pay at a rate higher or lower for all such services provided. The portion of the hospital stay during which the Member was not enrolled in the BHP will be paid by EOHHS at the psychiatric per diem rate for psychiatric services in a DMH-licensed bed or at the transfer per diem rate for substance abuse services and for psychiatric services in a non-DMH-licensed bed, capped at the Hospital-specific SPAD.
   (b) Payments to hospitals with network provider agreements with EOHHS's BH Contractor. When a Member enrolls in the BHP during an emergency or non-emergency psychiatric or substance abuse hospital admission, the portion of the hospital stay during which the Member was enrolled in the BHP shall be paid by EOHHS's BH Contractor at the rates agreed upon by the hospital and the BH Contractor provided that the hospital complies with the BH Contractor's service authorization and billing policies and procedures. The portion of the Hospital stay during which the Member was not enrolled in the BHP will be paid by EOHHS at the psychiatric per diem rate for psychiatric services in a DMH-licensed bed; or at the transfer per diem rate for psychiatric services in a non-DMH-licensed bed; or for substance abuse services, capped at the Hospital-specific SPAD.

(5) Rates of payment for Administrative Days (AD)

(a) Subject to all other requirements and limitations stated herein, payments for Administrative Days will be made only when provided to Members under age 21 or to Members who are receiving services in a DMH-licensed bed.

(b) Payments for ADs are made on a *per diem* basis. These *per diem* rates are all-inclusive and represent payment in full for all AD days in all acute care hospitals. For RY05 the AD rates are $198.47 for Medicaid/Medicare Part B eligible patients, and $214.63 for Medicaid-only patients. In most cases, a patient may not be admitted with AD status. Exceptions to this rule are outlined in the regulations of EOHHS. In most cases, therefore, ADs follow an acute stay in the hospital.

(c) For patients under 21 who return to acute status from AD status after 20 cumulative acute days in a single hospitalization, a hospital may receive outlier payments. If a patient returns to acute status after being on AD status, the hospital must add the acute days preceding the AD status to the acute days following the AD status in determining the day on which the hospital is eligible for outlier payments. The hospital may not bill for more than one SPAD where the patient fluctuates between acute status and AD status. The hospital may only bill for one SPAD, covering 20 cumulative Medicaid non-managed care acute days, and then for outlier days as specified in 114.1 CMR 36.05(3).

(6) Rates of Payment for Psychiatric and Substance Abuse Services

(a) Rates for Psychiatric Services in DMH-Licensed Beds. Services provided to MassHealth Members in DMH-licensed beds who are not enrolled with the BH Contractor or an MCO shall be paid through an all-inclusive regional weighted average per diem. This payment mechanism does not apply to cases in which psychiatric or substance abuse services are provided to Members assigned to the BHP or an MCO, except as set forth in EOHHS program regulations or contracts. The regions used to develop the all-inclusive regional weighted average per diem correspond to the Psychiatric Health Services Areas established by MassHealth as published in the 2005 Acute Hospital RFA. The rates and regions are as follows:

REGION	RATE
1	$806.24
2	$606.41
3	$618.22
4	$669.24
5	$669.24
6	$597.54

(b) Change of Managed Care Status During a Psychiatric or Substance Abuse Hospitalization. When a Medicaid member enrolls in the BHP during

a non-emergency or emergency mental health or substance abuse admission, the portion of the hospital stay during which the member was enrolled in the BHP shall be paid by EOHHS's BH contractor at the rates agreed upon by the hospital and the BH contractor provided that the hospital complies with the BH contractor's service authorization and billing procedures. The portion of the hospital stay during which the member was not enrolled in the BHP will be paid at the psychiatric per diem for psychiatric services or at the transfer per diem rate for substance abuse services, capped at the hospital-specific SPAD.

(7) Reimbursement for Unique Circumstances

(a) Sole Community Hospitals. DHCFP will determine if a hospital meets the criteria established in 114.1 CMR 36.02. In lieu of the standardized payment amount methodology described in 114.1 CMR 36.05(2)(b) the inpatient payment amount is equal to the sum of 95% of the hospital's FY98 cost per discharge capped at 200% of the statewide average payment amount per discharge, adjusted for casemix and inflation; and the hospital-specific RY05 pass-through amount per discharge and the capital amount per discharge calculated pursuant to 114.1 CMR 36.05(2)(c) and (d). Adjustments were made for casemix in accordance with the methodology described for casemix as stated in 114.1 CMR 36.05 (2) (b).

In addition, Sole Community Hospitals are eligible for outlier payments for patients under 21 whose length of stay during a single hospitalization exceeds 20 acute days, and are subject to the transfer payment provisions of 114.1 CMR 36.05(4).

(b) Specialty Hospitals and hospitals with Pediatric Specialty Units. EOHHS will determine whether a hospital meets the definition of a specialty hospital or hospital's with a pediatric specialty unit, as those terms are defined in 114.1 CMR 36.02. The inpatient payment amount for a specialty hospital and for pediatric specialty units is equal to the sum of 95% of the hospital's FY98 cost per discharge capped at 200% of the statewide average payment amount per discharge, adjusted for casemix and inflation; and the hospital-specific RY05 pass-through amount per discharge and the capital amount per discharge, calculated pursuant to 114.1 CMR 36.05(2)(c) and (d). Adjustments were made for casemix in accordance with the methodology described for casemix as stated in 114.1 CMR 36.05 (2) (b).

In addition, Specialty Hospitals are eligible for outlier payments for patients under 21 whose length of stay during a single hospitalization exceeds 20 acute days, and are subject to the transfer payment provisions of 114.1 CMR 36.05(4).

(c) Public Service and Municipal Acute Hospitals. DHCFP will determine whether a hospital meets this definition of a public service hospital, as that term is defined in 114.1 CMR 36.02.

1. Inpatient Reimbursement. For Public Service or Municipal Hospitals that merged on or after October 1, 1994, this methodology shall apply only to those hospital costs that EOHHS determines to be attributable to entities that had Public Service or Municipal Hospital status prior to the merger. The standard inpatient payment amount per discharge for Public Service and Municipal Hospitals shall be equal to the sum of: 95% of the hospital's FY98 cost per discharge capped at 200% of the statewide average payment amount, adjusted for casemix and inflation; and the hospital-specific RY05 pass-through amount per discharge and the capital amount per discharge. Adjustments were made for casemix in accordance with the methodology described for casemix as stated in 114.1 CMR 36.05 (2) (b).

   In addition, Public Service or Municipal Hospitals are eligible for outlier payments for patients under 21 whose length of stay during a single hospitalization exceeds 20 acute days, and are subject to the transfer payment provisions of 114.1 CMR 36.05(4).

2. Extraordinary Cost Reimbursement for Public Service and Municipal Acute Hospitals. EOHHS shall pay Public Service and Municipal Acute Hospitals an additional amount to recognize such hospitals' extraordinary costs of serving MassHealth Members; provided, however, that any such payment in excess of amounts that would otherwise be due any Public Service or Municipal Acute Hospital pursuant to this section is subject to legislative appropriation or authorization, compliance with all legislative conditions, including intergovernmental funds transfers whenever applicable, compliance with federal upper payment limit and other applicable regulations at 42 CFR Part 447, disproportionate share hospital limits at 42 USC 1396r-4(g), and the availability of federal financial participation at the rate of no less than 50 percent.

   The payment amount will be a percentage of the difference between the qualifying Hospital's total Medicaid charges and total Medicaid payments from any source, which percentage shall in no event exceed 100 percent of the costs of providing hospital services to MassHealth Members. Acute Hospitals that receive payment as Public Service or Municipal Acute Hospitals shall be determined by EOHHS.

(d) Non-profit acute care teaching hospitals affiliated with a Commonwealth-Owned University Medical School.

1. Subject to 114.1 CMR 36.05(7)(d)2., the inpatient payment amount for non-psychiatric admissions at non-profit acute care teaching hospitals affiliated with a Commonwealth-owned medical school will equal the hospital's cost per discharge calculated as follows. The data used for this

payment will be from the most recent submission of the hospital's, or predecessor hospital's, DHCFP 403 cost report(s). Total hospital-specific inpatient non-psychiatric charges are multiplied by the Hospital's inpatient non-psychiatric cost-to-charge ratio to compute the facility's inpatient non-psychiatric cost. The total inpatient non-psychiatric cost is then multiplied by the ratio of the hospital-specific non-psychiatric MassHealth discharges to the total hospital non-psychiatric discharges to yield the MassHealth inpatient non-psychiatric cost. The MassHealth inpatient non-psychiatric cost is then divided by the number of MassHealth non-psychiatric discharges to calculate the MassHealth cost per discharge. This MassHealth cost per discharge is multiplied by the inflation rates for those years between the year of the cost report and the current Rate Year.

2. Any payment in excess of amounts that would otherwise be due any non-profit teaching Hospital affiliated with a Commonwealth-owned medical school pursuant to 114.1 CMR 36.05(2)(b) through (h) and 114.1 CMR 36.07(3) through (6) is subject to specific legislative appropriation or authorization, compliance with all legislative conditions, compliance with federal upper payment limit and other applicable regulations, disproportionate share hospital limits, and the availability of federal financial participation.

(e) Essential MassHealth Hospitals.

1. Qualification. In order to qualify for payment as an Essential MassHealth Hospital, a hospital must meet at least four of the following criteria, as determined by EOHHS:

   a. The hospital is a non-state-owned public acute hospital;

   b. The hospital meets the current MassHealth definition of a non-profit teaching hospital affiliated with a Commonwealth-owned medical school;

   c. The hospital has at least 7% of its total patient days as Medicaid days;

   d. The hospital is an acute-care general hospital located in Massachusetts that provides medical, surgical, emergency and obstetrical services;

   e. The hospital enters into a separate contract with EOHHS relating to payment as an Essential MassHealth Hospital.

2. Reimbursement Methodology. Subject to legislative appropriation or authorization, compliance with all legislative conditions, including intergovernmental funds transfers whenever applicable, compliance with federal upper payment limit and other applicable regulations at 42 CFR Part 447, disproportionate share hospital limits at 42 USC 1396r-4(g), and the availability of federal financial participation at the rate of no less than

50 percent, EOHHS will make a supplemental payment, in addition to the standard reimbursement made under this RFA, to Essential MassHealth Hospitals. The payment amount will be: determined by EOHHS using data filed by each qualifying Hospital in its financial and cost reports; and, a percentage of the difference between the qualifying hospital's total Medicaid charges and total Medicaid payments from any source, which percentage shall in no event exceed 100 percent.

(f) Freestanding Pediatric Acute Hospital's Rate Add On. Subject to legislative authorization, compliance with federal upper payment limit and other applicable regulations at 42 CFR Part 447, disproportionate share hospital limits at 42 USC 1396r-4(g), and federal financial participation at the rate of no less than 50 percent, EOHHS will make a supplemental payment, in addition to the standard reimbursement made under this regulation, to Freestanding Pediatric Acute Hospitals, to account for high Medicaid volume.

The payment amount is determined by EOHHS based on data filed by each qualifying Hospital in its financial and cost reports, and projected Medicaid volume for the Hospital Rate Year. Payments to qualifying Hospitals in RY05 shall not exceed $5.79 million. Acute Hospitals that receive payment as Freestanding Pediatric Acute Hospitals shall be determined by EOHHS.

(8) Rehabilitation Unit Services in Acute Hospitals.

(a) Applicability. A per diem rate for rehabilitation services provided at an acute hospital shall apply only to acute hospital rehabilitation units operating at Public Service Hospitals in order to meet any remaining service needs following the closure of a public rehabilitation hospital.

(b) Payment Method. The per diem rate for such rehabilitation services will equal the average MassHealth RY05 rehabilitation hospital rate adjusted for inflation. This rate represents the average MassHealth RY05 rehabilitation hospital rate, weighted by volume of days, after removing the two lowest-rate rehabilitation hospitals from the average. Acute hospital administrative day rates will be paid for all days that a patient remains in the rehabilitation unit while not at acute or rehabilitation hospital level of care.

(9) Acute Hospitals with Proportionately High Medicaid Discharges.

(a) Applicability. Subject to legislative authorization, compliance with federal upper payment limit and other applicable regulations at 42 CFR Part 447, disproportionate share hospital limits at 42 USC 13965r-4(g), and federal financial participation at the rate of no less than 50 percent, EOHHS will make a supplemental payment, in addition to the standard reimbursement made under 114.1 CMR 36.00 to Acute Hospitals with Proportionately High Medicaid Discharges, as determined by EOHHS.

(b) Payment Method. The payment amount will be a percentage of the difference between the qualifying Hospital's total Medicaid costs and total Medicaid

payments from any source, which percentage shall in no event exceed 100 percent. Payments shall be subject to annual review to determine whether, in the Commonwealth's discretion, a supplemental payment is warranted to ensure adequate access and reasonable reimbursement levels at the hospital. Acute Hospitals that qualify for payment as an Acute Hospital with Proportionately High Medicaid Discharges shall be determined by EOHHS.

36.06: Determination of Medicaid Outpatient and Emergency Department Payment Rates for Disproportionate Share Hospitals and Sole Community Hospitals

(1) Applicability.

(a) Except as otherwise provided in 114.1 CMR 36.01(4), 114.1 CMR 36.06 establishes Medicaid outpatient and emergency department rates of payment to acute care hospitals that qualify for disproportionate share status and sole community hospital status under M.G.L. 118G and that enter into an agreement with EOHHS for provision of acute hospital services to MassHealth members. Disproportionate share hospital status is determined by the Division pursuant to 114.1 CMR 36.04.

(b) A hospital will be reimbursed in accordance with 114.1 CMR 36.06 for outpatient services provided by hospital outpatient departments, HLHCs, and satellite clinics.

(c) Rates for outpatient services covered under a contract between the acute hospital and the Behavioral Health Contractor or MassHealth Managed Care Organization (BH MCO) that are provided to Medicaid patients eligible for or assigned to EOHHS's BH Contractor or MCO are governed by terms agreed upon between the acute hospital and the BH Contractor or MCO, as applicable.

(2) Payment Amount Per Episode (PAPE). Except for those outpatient services specified in 114.1 CMR 36.06(2)(f), hospitals will receive a hospital-specific episodic payment, known as the Payment Amount Per Episode (PAPE).

(a) Rate Development. Each Hospital's PAPE is the product of the outpatient statewide standard and the hospital's casemix index. The base year for the PAPE is RY03, paid as of June 28, 2004.

(b) Outpatient Statewide Standard. The RY05 outpatient statewide standard is $120.56. For PPS-exempt hospitals, the outpatient statewide standard is 130% of the outpatient statewide standard for non-PPS-exempt hospitals, which in RY05 is $156.72.

(c) Casemix Index. The hospital-specific casemix index is the product of: a) the percentage change from the actual average APG weight per episode for FY02 to the projected average APG weight per episode for RY05; and, b) the repriced average APG weight per episode. In every case, the hospital-specific average APG weight per episode is calculated for the relevant period by dividing the

relevant payment by the conversion factor for the relevant period, and then by the number of episodes. For the PAPE base year, the standard APG conversion factor was $116.62. The pediatric conversion factor was $121.81

(d) Transition Buffer Payment. On or about April 1, 2005, EOHHS will calculate a hospital-specific comparison APG payment using claims for RY04 dates of service that adjudicated as payable as of March 31, 2005. The comparison APG payment will use a conversion factor of $119.26, which is the RY03 conversion factor of $116.62 multiplied by an inflation factor of 2.260%, which reflects price changes between RY03 and RY04. Additionally, the comparison APG payment will use RY02 outpatient cost-to-charge ratios. EOHHS will compare the total comparison APG payment to the total actual PAPE payment for RY04 dates of service for each hospital. For any hospital where the total RY04 actual PAPE payment is less than 95% of the comparison APG payment, EOHHS will pay the hospital the difference between the total PAPE payment for FY04 and 95% of the total comparison APG payment.

(e) Payment System. MassHealth processes and pays clean outpatient claims in accordance with 130 CMR 450 *et seq.*

(f) Excluded Services. The following services are excluded from the PAPE payment system:

1. Physician Services. See 114.1 CMR 36.06(3).
2. Hospital Outpatient Department and Emergency Department Services Payment Limitations. See 114.1 CMR 36.06(4).
3. Non-Emergency Services in Emergency Department. See 114.1 CMR 36.06(6).
4. Outpatient and Emergency Department Reimbursement for Non-Profit Acute Care Teaching Hospitals Affiliated with a Coomonwealth-Owned University Medical School. See 114.1 CMR 36.06(8).
5. Dental Services. Except when the conditions in EOHHS regulation 130 CMR 420.429(A) or (D) apply, see 114.1 CMR 36.06(9).
6. Other Services (in table):
   (a) Clinical Laboratory Services
   (b) Norplant System
   (c) Audiology Dispensing
   (d) Vision Care
   (e) Ambulance Services
   (f) Psychiatric Day Treatment Services
   (g) Adult Day Health Services
   (h) Early Intervention Services
   (i) Home Health Services
   (j) Adult Foster Care Services

(3) Physician Payments. A hospital may only receive reimbursement for physician services provided by hospital-based physicians or hospital-based entities to MassHealth

Members. The hospital will be reimbursed for the professional component of physician services in accordance with, and subject to: (1) the Physician Regulations at 130 CMR 433.000 et seq.; (2) the Acute Outpatient Hospital Regulations at 130 CMR 410.000 et seq.; and, (3) other rules regarding physician payment as set forth in 114.1 CMR 36.00.

(a) Such reimbursement shall be the lower of: (1) the fee established in the most current promulgation of DHCFP regulations 114.3 CMR 16.00, 17.00 and 18.00 (including the applicable facility fee for all services where such facility fee has been established); (2) the hospital's usual and customary charge for physician fees; or, (3) the hospital's actual charge submitted. Hospitals will not be reimbursed separately for professional fees for practitioners other than hospital-based physicians or hospital-based entities.

(b) Hospitals will be reimbursed for physician services only if the hospital-based physician or a physician providing services on behalf of a hospital-based entity took an active patient care role, as opposed to a supervisory role, in providing the outpatient service(s) on the billed date(s) of service.

(c) Physician services provided by residents and interns are not separately reimbursable.

(d) Hospitals will not be reimbursed for physician services if those services are: provided by a Community-Based Physician or Community-Based Entity; or, as further described in 114.1 CMR 36.06 (8).

(4) Hospital Outpatient Department and Emergency Department Services Payment Limitations.

(a) Payment Limitations on Hospital Outpatient and Emergency Department Services Preceding an Admission. Hospitals will not be separately reimbursed for hospital outpatient department or emergency department services when an inpatient admission to the same hospital, on the same date of service, occurs following the hospital outpatient department or emergency department visit; however, this payment limitation does not apply where an admission involving a one-day length of stay occurs on the same day following a surgical procedure.

(b) Payment Limitations on Outpatient Services to Inpatients. Hospitals will not be reimbursed for outpatient services provided to any Member who is concurrently an inpatient of any hospital. The hospital is responsible for payment to any other provider of services delivered to a Member while an inpatient of that hospital.

(5) Payment for Non-Emergency Services in Emergency Department.

(a) Required Screening. All Members presenting in the emergency department must be screened in the emergency department and stabilized in accordance with applicable requirements at 42 U.S.C. 1396dd et seq. and M.G.L. c.118E, section 17A and all applicable regulations.

(b) Payment for Emergency Services. Hospitals will be reimbursed for emergency services provided in the emergency department in the same manner as other outpatient services.

(c) Payment for Non-Emergency Services in the Emergency Department. Except as provided in 114.1 CMR 36.06 (5)(d) below, the emergency department facility screening fee of $61.34 is the exclusive reimbursement for hospitals providing non-emergency services in the emergency department.
(d) Hospitals will not be reimbursed an Emergency Department facility screening fee when the hospital bills a PAPE for the patient for the same date of service.
(e) Physician Payment. In addition to the emergency department screening fee described in 114.1 CMR 36.06 (5)(c), when a hospital-based physician or a hospital-based entity provides physician services in the course of providing non-emergency services in the emergency department, the hospital may be reimbursed an additional professional screening fee in accordance with 114.3 CMR 16.00, 17.00, and 18.00.

(6) Outpatient and Emergency Department Reimbursement for Non-Profit Acute Care Teaching Hospitals Affiliated with a Commonwealth-Owned University Medical School. Subject to 114.1 CMR 36.06(6)(b) and (c), the payment amount for outpatient and emergency department services at non-profit teaching hospitals affiliated with a Commonwealth-owned medical school shall be as follows. The data used for this payment will be from the most recent submission of a hospital's, or predecessor hospital's, DHCFP 403 cost report(s).

(a) The hospital's total outpatient charges are multiplied by the hospital's overall outpatient cost-to-charge ratio in order to compute the total outpatient costs. The total outpatient costs are then multiplied by the MassHealth outpatient utilization factor in order to calculate MassHealth outpatient costs. MassHealth outpatient costs are then multiplied by the inflation rates for those years between the year of the cost report and the current rate year.
(b) Any payment amount in excess of amounts that would otherwise be due any non-profit teaching hospital affiliated with a Commonwealth-owned medical school pursuant to 114.1 CMR 36.06 is subject to specific legislative appropriation or authorization, compliance with all legislative conditions, compliance with federal upper payment limit and other applicable regulations, disproportionate share hospital limits and the availability of federal financial participation.
(c) In no event will the payment set forth in this section exceed the costs incurred during the year of furnishing Hospital services to MassHealth Members.

(7) Dental Services. All covered dental services will be reimbursed by EOHHS, subject to all applicable regulations at 130 CMR 420.000 et seq. at the lower of the most current rates promulgated by the DHCFP as established in 114.3 CMR 14.00 et seq., or the hospital's usual and customary charge, except when the conditions in 130 CMR 420.429(A) or (D), 420.439, or 420.449(A) apply. When these conditions apply, EOHHS will reimburse the hospital according to 114.1 CMR 36.06(2).

(a) Physician Payment. Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of dental services, except when the conditions in 130 CMR 420.429(A) or (D) apply. Under those circumstances, in addition to the PAPE payment under 114.1 CMR 36.06(2), when a hospital-based physician or hospital-based entity provides physician services, the hospital may be reimbursed for such physician services in accordance with 114.1 CMR 36.06 (3).

(b) Payment Rates for HLHCs. A hospital that operates one or more hospital-licensed health centers (HLHCs) under its license may receive a dental enhancement fee for MassHealth-covered dental services provided, in accordance with 130 CMR 420 et seq. and 130 CMR 405.410, and 114.3 CMR 4.05(1). In order to receive the dental enhancement fee, the hospital must submit to MassHealth an executed HLHC Dental Partnering Project Agreement and comply with the terms set forth therein. Only those HLHCs that the hospital identifies are eligible for the dental enhancement fee.

(8) Other Services.

Regulation Title	**Payment will be lower of hospital's usual and customary charge or the rates set forth in:**	**Will hospital be reimbursed for hospital-based physician or hospital-based entity physician services related to provision of service?**	**Additional stipulations**
Laboratory Services	114.3 CMR 20.00 et seq.; or, the amount that would be recognized under 42 U.S.C. §13951(h) for tests performed for a person with Medicare Part B benefits.	No, except for surgical pathology services. The maximum allowable payment is payment in full for the laboratory service.	
Norplant System	114.3 CMR 12.00 et seq., only when a hospital-based physician inserts, removes, or reinserts Norplant System.	The hospital will only be paid for the hospital based physician payment, as the fee represents full payment in full for all services associated with the Norplant System.	
Audiology Dispensing	114.3 CMR 23.00	No.	
Vision Care	114.3 CMR 15.00	No.	Hospitals will be reimbursed for the dispensing of ophthalmic materials only by a hospital-based optometrist, ophthalmologist, or other practitioner licensed and authorized to write prescriptions for ophthalmic materials and services according to the Vision Care Regulations at 130 CMR 402.000 et seq.
Ambulance Services	114.3 CMR 27.00	No.	Payment is not made under

	et seq.		this section if the cost of the ground ambulance service was included by the hospital in the FY98 cost base for outpatient dept. services.
Psychiatric Day Treatment Services	114.3 CMR 7.03 et seq.	No.	Hospitals are not paid for psychiatric day treatment services in addition to outpatient clinic mental health services if both were delivered on the same day.
Adult Day Health Services	114.3 CMR 10.00 et seq.	Yes.	
Early Intervention Services	114.3 CMR 49.00 et seq.	Yes.	
Home Health Services	114.3 CMR 3.00 et seq.	Yes.	
Adult Foster Care Services	The rates developed by EOHHS.	Yes.	

36.07: Disproportionate Share Payment Adjustments

(1) Overview.

(a) Applicability. The Medicaid program assists hospitals that carry a disproportionate financial burden of caring for the uninsured and publicly-insured persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid makes an additional payment adjustment above the rates established under 114.1 CMR 36.05 and 114.1 CMR 36.06 to hospitals that qualify for such an adjustment under any one or more of the following classifications. Medicaid payment adjustments for disproportionate share hospitals are a source of funding for allowable uncompensated care costs.

(b) Eligibility. Only hospitals that have an executed contract with EOHHS are eligible for disproportionate share payments. Medicaid participating hospitals may qualify for adjustments and may receive them at any time throughout the year. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating those adjustments are described in 114.1 CMR 36.07. When hospitals apply to participate in the Medicaid program, their eligibility and the amount of their adjustment is determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following disproportionate share hospital (DSH) classifications (114.1 CMR 36.07). If a hospital's Medicaid contract is terminated, any adjustment is prorated for the portion of the year during which it had a contract, the remaining

funds it would have received are apportioned to remaining eligible hospitals. This means that some DSH adjustments may require recalculation. Hospitals are informed if an adjustment amount changes due to reapportionment among the qualified group and told how overpayments or underpayments by EOHHS are handled at that time. To qualify for a DSH payment adjustment under any classification within 114.1 CMR 36.07, a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. § 1396r-4(d) or qualify for the exemption described at 42 U.S.C. § 1396r-4(d)(2). In addition, to qualify for a DSH payment adjustment under 114.1 CMR 36.07 a hospital must have a Medicaid inpatient utilization rate, calculated by dividing Medicaid patient days by total days, of not less than 1%.

(c) DSH Limits. Except as provided below for qualifying public hospitals, the total amount of DSH payment adjustments awarded to a particular hospital under 114.1 CMR 36.07 cannot exceed the costs incurred during the year by the hospital for furnishing hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third party coverage less payments received by the hospital for medical assistance and from uninsured patients, and as provided at 42 U.S.C. § 1396r-4(g). In accordance with Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000 (BIPA), total disproportionate share hospital adjustments for state fiscal years 2004 and 2005, for qualifying public hospitals will not exceed 175 percent of the uncompensated cost of care to Medicaid-eligible and uninsured individuals. The Division may adjust payments if the Division determines that the amounts calculated for a particular hospital would exceed the hospital-specific DSH limit. These adjustments may be made on a prospective or retrospective basis.

(2) High Public-Payer Hospital Disproportionate Share Adjustment

(a) Eligibility. Hospitals determined eligible for disproportionate share status pursuant to 114.1 CMR 36.04 are eligible for the adjustment in 114.1 CMR 36.07(2)(b).

(b) Calculation of Adjustment.

1. EOHHS allocates $11.7 million for this payment adjustment.

2. The Division then calculates for each eligible hospital the ratio of its allowable free care charges, as defined in M.G.L. c. 118G, to total charges. The Division will obtain free care charge data from the hospitals UC-Form filings, on a fiscal year basis consistent with the data cited in 114.1 CMR 36.04(2)(a).

3. The Division then ranks the eligible hospitals from highest to lowest by the ratios of allowable free care to total charges determined in 114.1 CMR 36.07(2)(b)2.

4. The Division then determines the 75th percentile of the ratios determined in 114.1 CMR 36.07(2)(b)2.

5. Hospitals that meet or exceed the 75th percentile qualify for a High Public-Payer Hospital Adjustment. The Division multiplies each qualifying hospital's allowable free care charges by the hospital's most recent cost to charge ratio, as calculated pursuant to 114.6 CMR 11.04 to determine allowable free care costs.

6. The Division then determines the sum of the amounts determined in 114.1 CMR 36.07(2)(b)5 for all hospitals that qualify for a High Public-Payer adjustment.

7. Each eligible hospital's High Public-Payer Hospital adjustment is equal the amount allocated in 114.1 CMR 36.07(2)(b)1 multiplied by the amount determined in 114.1 CMR 36.07(2)(b)5 and divided by the amount determined in 114.1 CMR 36.07(2)(b)6.

(3) Basic Federally-Mandated Disproportionate Share Adjustment

(a). The Division determines a federally-mandated Medicaid DSH adjustment for all eligible hospitals, using the data and methodology described below. The Division uses the following data sources in its determination of the federally-mandated Medicaid DSH adjustment, unless the specified data source is unavailable. If the specified data source is unavailable, then the Division determines and uses the best alternative data source.

1. The Division uses free care charge data from the prior year filing of the Division's uncompensated care reporting form..

2. The prior year RSC-403 report is used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient charges, and the state and/or local cash subsidy.

(b). The Division calculates a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of acute care hospitals for the federally-mandated disproportionate share adjustment. The Division determines such threshold as follows:

1. First, the statewide weighted average Medicaid inpatient utilization rate is calculated. This is determined by dividing the sum of Medicaid inpatient days for all acute care hospitals in the state by the sum of total inpatient days for all acute care hospitals in the state.

2. Second, the statewide weighted standard deviation for Medicaid inpatient utilization statistics is calculated.

3. Third, the statewide weighted standard deviation for Medicaid inpatient utilization is added to the statewide average Medicaid inpatient utilization rate. The sum of these two numbers is the threshold Medicaid inpatient utilization rate.

4. Lastly, each hospital's Medicaid inpatient utilization rate is calculated by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1

CMR 36.07(3)(b)3., then the hospital is eligible for the federally-mandated Medicaid DSH adjustment under the Medicaid utilization method.

(c). The Division then calculates each hospital's low-income utilization rate as follows:

1. First, the Medicaid and subsidy share of gross revenues is calculated as follows:

$$\frac{\text{Medicaid gross revenues + state and local government cash subsidies}}{\text{Total revenues + state and local government cash subsidies}}$$

2. Second, the free care percentage of total inpatient charges is calculated by dividing the inpatient share of free care charges less the portion of state and local government cash subsidies for inpatient services by total inpatient charges.

3. Third, the low-income utilization rate is calculated by adding the Medicaid and subsidy share of total revenues calculated pursuant to 114.1 CMR 36.07(3)(c)1 to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 36.07(3)(c)2. If the low-income utilization rate exceeds 25%, the hospital is eligible for the federally-mandated DSH adjustment under the low-income utilization rate method.

(d). Payment Methodology. The payment under the federally-mandated DSH adjustment requirement is calculated as follows:

1. For each hospital determined eligible for the federally-mandated Medicaid DSH adjustment under the Medicaid utilization method established in 114.1 CMR 36.07(3), the Division divides the hospital's Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)4 by the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)3. The resulting ratio is the federally-mandated Medicaid DSH ratio.

2. For each hospital determined eligible for the basic federally mandated Medicaid DSH adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid DSH adjustment under the Medicaid utilization method, the Division divides the hospital's low-income utilization rate by 25%. The resulting ratio is the federally-mandated Medicaid DSH ratio.

3. The Division then determines, for the group of all eligible hospitals, the sum of federally-mandated Medicaid DSH ratios calculated pursuant to 114.1 CMR 36.07(3)(d)1. and 114.1 CMR 36.07(3)(d)2.

4. The Division then calculates a minimum payment by dividing the amount of funds allocated pursuant to 114.1 CMR 36.07(3)(e) by the sum of the federally-mandated Medicaid DSH ratios calculated pursuant to 114.1 CMR 36.07(3)(d)3.

5. The Division then multiplies the minimum payment by the federally-mandated Medicaid DSH ratio established for each hospital pursuant to 114.1 CMR 36.07(3)(d)1 and 2. The product is the payment under the federally-mandated DSH adjustment requirement. This payment ensures that each hospital's utilization rate exceeds one standard deviation above the mean, in accordance with 42 U.S.C. § 1396r-4.

(e). The total amount of funds allocated for payment to acute care hospitals under the federally-mandated Medicaid DSH adjustment requirement is $200,000 per year. These amounts are paid by EOHHS, and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 36.07(3)(d)5.

(4) Disproportionate Share Adjustment for Safety-Net Providers. The Division determines a DSH safety-net adjustment factor for all eligible hospitals, using the data and methodology described in 114.1 CMR 36.07(4).

(a) Data Sources. The Division uses free care charge data from the prior year's filing of the Division's UC report and total charges from the DHCFP-403. If the specified data source is unavailable, then the unreimbursed costs are calculated using the best alternative data available.

(b) Eligibility of Disproportionate Share Hospitals for the Safety-Net Provider Adjustment. The DSH adjustment for safety-net providers is a payment for any hospital that:

1. is a public or public-service hospital as defined in 114.1 CMR 36.02;
2. has a volume of Medicaid and free care charges in FY93, or for any new hospital, in the base year as determined by DHCFP that is at least 15% of its total charges;
3. is an essential safety-net provider in its service area, as demonstrated by delivery of services to populations with special needs including persons with AIDS, trauma victims, high-risk neonates, or indigent or uninsured patients;
4. has completed an agreement, or is the specified beneficiary of an agreement, with EOHHS for intergovernmental transfer of funds, as defined in federal regulations governing state financial participation as a condition of federal reimbursement, to the Medicaid program for the DSH adjustment for safety-net providers (the public entity obligated to make an intergovernmental funds transfer must also in fact meet its obligation in accordance to this criterion); and,
5. is the subject of an appropriation requiring an intergovernmental funds transfer.

(c) Payment to Hospitals under the Adjustment for Safety-Net Providers. The Division calculates an adjustment for hospitals that are eligible for the safety-net provider adjustment, pursuant to 114.1 CMR 36.07(4)(b). This adjustment shall be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients,

and equals the amount of funds specified in an agreement between EOHHS and relevant governmental unit. Payments will be made by EOHHS to eligible hospitals subject to legislative appropriation or authorization, compliance with all legislative conditions, compliance with disproportionate share hospital limits at 42 U.S.C 1396r-4, and the availability of federal financial participation at the rate of no less than 50%. (d). If a public entity has not met its obligation to make an intergovernmental funds transfer, EOHHS shall have the right to recoup any safety-net DSH payment amount which is conditioned on the receipt by the Commonwealth of said intergovernmental funds transfer.

(5) Uncompensated Care Disproportionate Share Adjustment. Hospitals eligible for this adjustment are those that report free care costs, as defined by 114.6 CMR 11.00, and who are participating in the free care pool administered by the Division pursuant to M.G.L. c. 118G. The payment amounts for eligible hospitals are determined by the Division in accordance with its regulations at 114.6 CMR 11.00. These payments are made to eligible hospitals in accordance with the Division's regulations and the interagency service agreement (ISA) between EOHHS and DHCFP. Eligible hospitals receive these payments on a periodic basis during the term of their RY05 hospital contract with EOHHS.

(6) Public Health Substance Abuse Disproportionate Share Adjustment. Hospitals eligible for this adjustment are those acute facilities that provide hospital services to low-income individuals who are uninsured or are covered only by a wholly state-financed program of medical assistance of the Department of Public Health (DPH), in accordance with regulations set forth at 105 CMR 160.000, as limited in DPH's ISA with EOHHS. The payment amounts for eligible hospitals participating in the Public Health Substance Abuse program are determined and paid by DPH in accordance with regulations at 114.3 CMR 46.00 and DPH's ISA with EOHHS.(7) Disproportionate Share Adjustments for Pediatric Specialty Hospitals and Units.

Eligibility. In order to be eligible for this adjustment, the hospital must meet the definition of a Pediatric Specialty Hospital or Unit as defined in 114.1 CMR 36.02. In addition, the hospital must have a signed contract with EOHHS for the period that such adjustment is in effect.

(a) Methodology. The Division will calculate an adjustment as follows:

1. For each eligible hospital, the Division will calculate the ratio of MassHealth pediatric days to the total MassHealth pediatric days for all eligible hospitals.
2. The Division will multiply the ratio calculated in 114.3 CMR 36.07(7)(b)(1) by the total allocation cited in 114.3 CMR 36.07(7)(c) to determine the payment amount for each hospital.
3. The DSH adjustment will reimburse only those costs that have not otherwise been reimbursed and will be paid subject to the availability of federal financial participation.

(c) Payment Amount. The total amount of funds allocated for payment to hospitals will be the amount appropriated for such. These amounts are determined pursuant

to 114.1 CMR 36.07(7)(b). Payments are made by EOHHS and distributed among eligible hospitals determined pursuant to 114.1 CMR 36.07(7)(a).

36.08: Medicaid Rates of Payment for Emergency Services at Hospitals that Do Not Contract with EOHHS

(1) Overview: 36.08 establishes rates of payment to acute care hospitals who have not signed a contract with EOHHS. Rates of payment for all emergency services and continuing emergency care provided in an acute hospital to medical assistance program members, including examination or treatment for an emergency medical condition or active labor in women or any other care rendered to the extent required by 42 USC 1395 (dd) are as follows:

(2) Payment for emergency inpatient admissions is made using the transfer *per diem* rate of payment, established according to the methodology set forth in 114.1 CMR 36.05(4), up to the hospital-specific standard payment amount per discharge, established according to the methodology set forth in 114.1 CMR 36.05(2)(c). If the data sources specified in 114.1 CMR 36.05(9) are not available, or if other factors do not permit precise conformity with the provisions of 114.1 CMR 36.05, the Division will select such substitute data sources that the Division determines appropriate in determining hospitals' rates. Hospitals must notify EOHHS within 24 hours of admitting a Medicaid beneficiary in order to be eligible for payment pursuant to 114.1 CMR 36.08.

(3) Rates of payment for emergency outpatient services provided in a hospital emergency department, outpatient department, or hospital-licensed heath center will be paid at the rates established at 114.1 CMR 36.06.

(4) Rates of payment for outpatient emergency services provided by a hospital-based physician are established according to the methodology set forth in 114.1 CMR 36.06(12).

(5) Rates of payment for services provided by a hospital-based physician to a patient admitted as an inpatient in an emergency situation will be paid according to the methodology set forth at 114.1 CMR 36.05(2)(i).

36.09: Upper Limit

Medicaid rates of payment calculated under the provisions of 114.1 CMR 36.05 conform to the upper limit requirement imposed by Title XIX of the Social Security Act, which requires that states certify that hospital payments in the aggregate do not exceed the amount of payments that would result if payments were based on the Medicare principles of reimbursement. Rates of payment established pursuant 114.1 CMR 36.00 may be adjusted if it is determined that aggregate payments exceed this limit or if adjustments are required by the Centers for Medicare and Medicaid Services (CMS). Such adjustments may be made on either a prospective or retrospective basis.

(1) FFP Denials. If any portion of the reimbursement pursuant to 114.1 CMR 36.00 is not approved or is the basis of a disallowance by CMS, EOHHS may recoup, or offset against future payments, any payment made to a hospital in excess of the approved reimbursement.

(2) Exceeding Limits

(a) Hospital-Specific Limits. If any payments made pursuant to 114.1 CMR 36.00 exceed federal hospital-specific payment limits, including, but not limited to, charge limits, upper payment limits, and disproportionate share hospital payment limits (see 42 CFR Part 447; 42 USC 1396r-4), EOHHS may recoup, or offset against future payments, any payment made to a Hospital in excess of the applicable limit.
(b) Aggregate Limits. If any payments made pursuant to 114.1 CMR 36.00 exceed federal aggregate payment limits, including, but not limited to upper payment limits and disproportionate share hospital payment limits (see 42 CFR Part 447; 42 USC 1396r-4), EOHHS may exercise its discretion to apportion the disallowance among the affected hospitals and to recoup from, or offset against future payments to such hospitals, or to otherwise restructure payments in accordance with approved payment methods.

36.10: Hospital Mergers and New Hospitals

(1) Hospital Mergers. For any hospital that is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership, or operation of the hospital during the fiscal year, the Division may make adjustments to the hospitals' rates. The Division will determine the best available data source(s) for these adjustments.
(2) New Hospitals. The rates of reimbursement for new hospitals shall be determined in accordance with the provisions of 114.1 CMR 36.00 to the extent the Division deems possible. If the data sources specified in 114.1 CMR 36.07 are not available, or if other factors do not permit precise conformity with the provisions of 114.1 CMR 36.07, the Division will select such substitute data sources that the Division deems appropriate in determining hospitals' rates.

36.11: Administrative Adjustment

(1) If, at its own initiative, the Division concludes that an error has been made in a determination made pursuant to 114.1 CMR 36.00, it may correct such error.
(2) A hospital may apply for an administrative adjustment if the hospital believes an arithmetic, mechanical, or clerical error exists in a determination made pursuant to 114.1 CMR 36.00. The Division will not entertain a request for an administrative adjustment if the hospital is seeking to reverse a substantive determination pursuant to 114.1 CMR 36.00. The request for administrative adjustment must be received at the Division within 20 business days of the date of notification of the Division's determination. The request must be in writing and contain a precise explanation of the perceived error as well as any documentation to support the request.
(3) In the event that, during a contract year, a hospital opens or closes an inpatient service that the hospital believes will have a significant effect on casemix, the hospital must provide EOHHS with a data analysis of the casemix effect if it requests a casemix adjustment. EOHHS may, in its sole discretion, consider revised data submitted by the hospital.

36.12: Penalties

An acute care hospital that makes a charge or accepts payment based upon a charge in excess of that filed with the Division or which fails to file any data, statistics, schedules, or other information pursuant to 114.1 CMR 36.00 or which falsifies same, shall be subject to a civil penalty of not more than $1000 for each day on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the Commonwealth in any court of competent jurisdiction. The Attorney General shall bring any appropriate action, including injunction relief, as may be necessary for the enforcement of the provisions of 114.1 CMR 36.00.

36.13: Severability

The provisions of 114.1 CMR 36.00 are hereby declared to be severable if any such provisions or the application of such provisions to any hospital or circumstances shall be held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any of the remaining provisions of 114.1 CMR 36.00 or the application of such provisions to hospitals or circumstances other than those held invalid.

REGULATORY AUTHORITY

114.1 CMR 36.00: M.G.L. 118G, and St. 1991, c. 495.